



**An Information Service of the Division of Medical Assistance**

**North Carolina  
Medicaid Pharmacy  
Newsletter**

***Number 123***

***May 2005***

**In This Issue...**

**Facts for Providers Regarding the Medicare Prescription Drug Plans**

**New Medicare Prescription Drug Program**

**Compliance Date for HIPAA Electronic Transactions**

**Changes in Drug Rebate Manufacturers**

**Update to FUL Changes**

**NDC Deletions Update**

**Change in Drug Coverage Status/DESI Code Change**

**Non-Drug Deletions from Drug File**

Published by EDS, fiscal agent for the North Carolina Medicaid Program  
1-800-688-6696 or 919-851-8888

## **Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006--Provider Action Needed**

**The following article is reprinted from Medlearn Matters with permission from CMS.**

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003. This new drug coverage requires **every** Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1-800-MEDICARE and <http://www.medicare.gov>. It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

### **The Basic Plan**

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006 or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs. Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around \$37 in 2006); and,
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

- What prescription drugs are covered;
- How much the beneficiary pays; and,
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage and additional medications. When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs. The following questions and answers provide key information that might be of interest to you, your staff, or your patient.

### **When can your patients enroll in this new plan?**

If a beneficiary currently has Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005 and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006; and,
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

**What if the Medicare beneficiary cannot pay for a Medicare prescription drug plan?**

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. In mid-2005, the Social Security Administration (SSA) will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the SSA or their local Medicaid office as early as the summer of 2005.

**Will this new plan work with other Medicare coverage that your patients may have?**

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the Original Medicare Plan (these plans will be offered by insurance companies and other private companies); and,
- Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs) in some areas.

**What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?**

The Medicare beneficiary will get a detailed notice from their insurance company or the employer or union informing them whether their policy covers as much or more than a Medicare prescription drug plan.

This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:

- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher; or,
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:

- Keep their current drug plan and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or,
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or,
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

**Additional Information**

More information on provider education and outreach regarding drug coverage can be found at:

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit:

<http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf>

You can also find additional information regarding prescription drug plans at:

<http://www.cms.hhs.gov/pdps/>

Further information on CMS implementation of the MMA can be found at the following CMS web site:

<http://www.cms.hhs.gov/medicarereform/>

## **New Medicare Prescription Drug Program -- Provider Action Needed**

**The following article is reprinted from Medlearn Matters with permission from CMS.**

### **STOP – Impact to You**

On January 1, 2006, a very important new benefit will be available to your Medicare patients. These new Medicare Prescription Drug Plans will be of significant value to your patients by providing assistance with prescription drug expenses. This program is authorized under the Medicare Modernization Act of 2003 (MMA). Your patients may ask you about this new benefit.

### **CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) is preparing an extensive campaign for both providers and beneficiaries, and will be disseminating information to these audiences. Over the next year, as materials are developed, you will be notified through a series of Medlearn Matters articles and other resources. Some providers will choose to be active in giving information to their Medicare patients, and we will help you do that. CMS encourages and appreciates the work providers are willing to do to help people with Medicare learn about this important new benefit.

### **GO – What You Need to Do**

Stay informed. Go to the newly established web site:

<http://www.cms.hhs.gov/medicarereform/pdbma/> and check it often as new information is always being added. This easy-to-use website has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations. Users can follow the menu and select the area that best matches their area of interest. Refer your Medicare patients to information resources – **1-800- MEDICARE** and [www.medicare.gov](http://www.medicare.gov).

### **Background**

On December 8, 2003, the Medicare Modernization Act (MMA) was enacted, adding a very important new benefit to the Medicare program. This new benefit takes effect on January 1, 2006, and provides a much needed new drug benefit to help serve the 41 million Americans who rely on Medicare for their health care needs. On January 21, 2005, Health and Human Services Secretary Tommy G. Thompson announced the final regulations establishing the new Medicare prescription drug benefit program. This is a very important step in making this great addition to the Medicare program a reality for your Medicare patients. This is a very special time for your patients with Medicare, full of many exciting program improvements and enhancements. Great opportunities exist right now through the MMA to make the Medicare program more personalized and more up-to-date, and to keep it up-to-date. The Medicare Drug Benefit is a major step in that direction. A very important step toward fulfilling that opportunity is in the final regulation for the Medicare Drug Benefit Program. Along with the new Medicare Preventive benefits, this major program improvement brings Medicare's coverage up-to-date with 21st Century prevention-minded medicine.

### **WE NEED YOUR HELP**

Because people with Medicare trust their physicians, other clinicians, pharmacists, and other health care providers, you are in a unique position to direct them to the resources available to help them learn about the new benefit. If any of your patients rely on caregivers, CMS appreciates your efforts to get this information into their hands as well.

CMS will be pursuing a number of activities to make sure the physician, provider, and supplier communities know about this new benefit, understand how it works, and will be highlighting the information that may be of most value to your Medicare patients. As educational materials are developed, you will be notified of their availability. These materials will help you and your staff understand the new benefit. CMS will keep you up-to-date with education and outreach efforts on the new drug benefit.

Here's how you can stay connected:

- Pay attention to correspondence from your Medicare carrier or fiscal intermediary or your national professional associations---they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listserve and read their newsletters;
- Register to receive listserv email messages to alert you when new Medlearn Matters articles have been released on the new drug benefit (and other Medicare information). Medlearn Matters articles provide succinct and timely messages on Medicare claims processing and other changes. These articles can be found on the web at <http://www.cms.hhs.gov/medlearn/matters>.
- Participate in CMS Open Door Forums to hear from and ask questions of CMS leadership on topics of interest to your particular provider-type. Information regarding these Open Door Forums may be found on the web at: <http://www.cms.hhs.gov/opendoor>

## Compliance Date for HIPAA Electronic Transactions

Effective October 1, 2005, N.C. Medicaid will cease acceptance of non-Health Insurance Portability and Accountability Act (HIPAA) compliant transaction formats. Providers currently filing on non-HIPAA compliant formats need to be advised of this date and make the necessary changes to ensure compliance. The following article includes information regarding HIPAA, the importance of compliance and recommendations to become compliant.

HIPAA legislation requires standardized transmission of electronic information. Covered entities were required to comply with these standards by October 16, 2003. Covered entities are defined in HIPAA as:

1. Health plans.
2. Health care clearinghouses or vendors.
3. Health care providers who transmit any health information in electronic format in connection with a transaction covered in the HIPAA Transaction Rule. These terms are defined in detail in 45 CFR 160.103.

N.C. Medicaid, as a covered entity, satisfied the HIPAA compliance date by implementing the American National Standard Institute (ANSI) Accredited Standards Committee (ASC) X12N standards, Version 4010A1 for the following transactions on October 16, 2003:

- Health Care Claim (Professional, Institutional, Dental) – 837 Transaction
- Health Care Claim Payment Advice – 835 Transaction
- Claim Inquiry and Response – 276/277 Transaction
- Benefit Enrollment Maintenance – 834 Transaction
- Payroll Deducted and Other Group Premium Payment for Insurance Products – 820 Transaction
- Eligibility Benefit Inquiry/Response – 270/271 Transaction
- Health Care Services Review and Response – 278 Transaction

N.C. Medicaid also implemented the National Council for Prescription Drug Programs (NCPDP), Versions 1.1 Batch and 5.1 Point-of-Sale as the standard for all retail pharmacy transactions in accordance to HIPAA legislation. **NCECS batch will not be accepted after October 1, 2005.**

Although the compliance date as set under HIPAA was October 16, 2003, CMS allowed payers, including North Carolina Medicaid, to continue accepting non-compliant formats to minimize creating financial hardship for the associates with whom they exchange transactions. N.C. Medicaid has been accepting both compliant

and non-compliant transactions since October 16, 2003. October 1, 2005 marks the date N.C. Medicaid will cease accepting transactions on non-compliant electronic formats.

## **Compliance Options**

Provider's currently submitting claims via non-HIPAA compliant formats have several options for meeting the compliance date indicated above. These options are briefly detailed below.

1. Vendor - Providers may purchase HIPAA compliant software from a vendor which allows the creation of HIPAA compliant transactions. Providers who exercise this option will be required to have a Trading Partner Agreement on file, and the Vendor will have to complete transaction testing before they are allowed to submit transactions in production to N.C. Medicaid.
2. Clearinghouse – Providers may contract for the services of a clearinghouse. A clearinghouse acts as a middle-man between the Provider and Payor/Payer. Providers submit claims to the clearinghouse; in turn, the clearinghouse forwards the transactions to payers for adjudication. Under this option, the Trading Partner Agreement will exist between the clearinghouse and N.C. Medicaid since the clearinghouse is the actual entity submitting transactions to N.C. Medicaid on behalf of the Provider.
3. In-House – Providers with technical staff or services may create their own transactions based upon the standard electronic formats. As with the vendor solution, providers will be required to have a trading partner agreement on file and test with Medicaid before transactions can be filed in production.
4. NCECSWeb - Providers may file claims directly to North Carolina Medicaid on NCECSWeb. NCECSWeb replaces all previous versions of N.C. Medicaid created claims filing software such as NECS and NCECS. NCECSWeb is a claims filing tool only and is only compatible with N.C. Medicaid. NCECSWeb complies with the data content standards required by HIPAA.

Providers are encouraged to begin the transition to one of these HIPAA compliant formats immediately to ensure ample time to test and address compliance errors, if necessary. Regardless of the option selected, all providers who wish to file claims electronically will be required to have an Electronic Claims Submission Agreement form on file for their provider number.

Providers should ensure vendors, clearinghouses, and other associates with whom they conduct business are HIPAA-compliant. Providers must also be aware that HIPAA is federal legislation and impacts more than N.C. Medicaid. It may be necessary for providers to make changes in claims filing practices with all associated health plans.

## **Additional Information**

Implementation guides for the ASC X12N and NCPDP transactions listed in this bulletin article have been established as the standard for HIPAA compliance. The implementation guides for ASC X12N transactions are available at <http://www.wpc-edi.com>. The NCPDP (Pharmacy) implementation guide is available at <http://www.ncpdp.org>. The guides offer a detailed layout for standard transaction formats.

In addition, to ensure a seamless transition from non-compliant electronic formats to HIPAA standard formats, companion guides have been published. These guides provide specifics required to successfully exchange transactions electronically with North Carolina Medicaid in ASC X12 and NCPDP standard format. The information contained in the guides is for billing providers, their technical staff, clearinghouses, or vendors. N.C. Medicaid companion guides are available at <http://www.dhhs.state.nc.us/dma/hipaa/compguides.htm>. Please visit the website on a regular basis to see if changes have been made to the companion guides that may impact your electronic transaction exchange with EDS.

Additional helpful information regarding HIPAA legislation can be found at:

- Centers for Medicare and Medicaid Services' HIPAA page: <http://www.cms.hhs.gov/hipaa>
- Workgroup for EDI — HIPAA page: <http://www.wedi.org>
- Medicaid Special Bulletin, June 2003 HIPAA Update  
<http://www.dhhs.state.nc.us/dma/bulletin/0603specbull.htm>

For questions, please contact EDS Electronic Commerce Services at 1-800-688-6696, or 919-851-8888, option 1.

## Changes in Drug Rebate Manufacturers

The following changes are being made in manufacturers with Drug Rebate Agreements. They are listed by manufacturer code, which are the first five digits of the NDC.

### Additions

The following labelers have entered into Drug Rebate Agreements and joined the rebate program effective on the dates indicated below:

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
10122	Cornerstone Biopharma, Inc	4/26/2005
10148	Cotherix, Inc.	4/21/2005
66593	Viro Pharma, Incorporated	4/18/2005

### Terminated Labelers

The following labeler code was voluntarily terminated effective **April 1, 2005**:

Ranbaxy Laboratories, Inc., (labeler code 10631)

The following labeler codes are being voluntarily terminated effective **July 1, 2005**:

Niche Pharmaceuticals (labeler code 59016); and,  
Aslung Pharmaceutical, L.P. (labeler code 65271).

The following labeler codes are being terminated effective **July 1, 2005**:

Steris Laboratories (labeler code 00402);  
Berlex Laboratories (labeler code 11994);  
Jerome Stevens Pharmaceuticals, Inc. (labeler code 50564);  
Speywood Pharmaceuticals, Inc. (labeler code 55688);  
Elge, Inc. (labeler code 58298);  
Kiel Laboratories, Inc. (labeler code 59063);  
AM2PAT, Inc., (labeler code 65054); and,  
Morepen Max, Inc. (labeler code 67836).

## Reinstated Labelers

Gemini Pharmaceuticals, Inc. (labeler code 51645) has signed a new rebate agreement. Due to special circumstances, this reinstated labeler is permitted an optional coverage effective date of 02/12/2005. The mandatory coverage effective date is 07/01/2005.

OHM Laboratories, Inc. (labeler code 51660) has signed a new rebate agreement with a mandatory coverage effective date of 07/01/2005. There is no optional coverage date for this reinstated labeler.

## Update to FUL Changes

Per CMS, the Federal Upper Limit (FUL) changes that were recently released dated 4-8-05, included three strengths of Hydrochlorothiazide; Quinapril Hydrochloride (12.5mg; 20mg, and 25mg;20mg) were erroneously added to the FUL list. All three strengths do not, at this time, meet the criteria for a FUL. Therefore, CMS is retracting these three drugs from this FUL update.

The following three Hydrochlorothiazide; Quinapril Hydrochloride will be deleted from the FUL:

### Strength

12.5mg;10mg,Tablet, Oral

12.5mg;20mg, Tablet, Oral

25mg;20mg, Tablet, Oral

## NDC Deletions Update

Many of the NDC's listed as non-covered in the January Pharmacy Newsletter due to not being properly listed with the FDB have been reinstated and are now showing as covered. The NDC's that are still showing as non-covered are the following:

00115-3911-01	00115-3922-01	51672-3001-02	51672-3002-04	55390-0067-10
55390-0101-10	60258-0429-16	66323-0306-30	66424-0520-35	66591-0631-51
66977-0222-02	68094-0512-61	68094-0512-62		

Drug coverage can always be determined via the POS system or the voice inquiry system.

## Change in Drug Coverage Status/DESI Code Change

States were previously informed, via a state fax that went out on April 6, 2005, of several products for which the DESI codes were reported incorrectly. Those products are as follows:

00496-0716	Pramosone Cream 1%
00496-0717	Pramosone Cream 2.5%
00496-0726	Pramosone Lotion 2.5%
00496-0729	Pramosone Lotion 1%
00496-0763	Pramosone Ointment 1%
00496-0777	Pramosone Ointment 2.5%

Although the labeler of these products provided a DESI Code 2 (safe and effective) for each NDC, the FDA has determined that these drugs are less-than-effective, or a DESI Code 5. North Carolina has made this change to the drug file.

### Non-Drug Deletions From Drug File

In accordance with previously released state faxes and as part of CMS's continuing effort to remove non-drug items from the Medicaid Drug Rebate (MDR) system, the following products were deleted from the MDR Master file of covered outpatient drugs and are no longer covered by NC Medicaid **effective April 1, 2005**.

00517-2802-25 Sodium Chloride Injection, USP 0.9%  
 00517-2810-25 Sodium Chloride Injection, USP 0.9%  
 64054-0902-03 Sodium Chloride 0.9% 2 ml Fill In 3 ml SYR  
 64054-0903-02 Sodium Chloride 0.9% 3 ml Fill In 12 ml SY  
 64054-0903-03 Sodium Chloride 0.9% 1 ml Fill In 3 ml SYR  
 64054-0903-06 Sodium Chloride 0.9% 3 ml Fill In 6 ml SYR  
 64054-0903-12 Normal Saline IV Flush Syringe 3 ml Fill/12 ml Syringe  
 64054-0905-02 Sodium Chloride 0.9% 5 ml Fill In 12 ml SY  
 64054-0905-06 Sodium Chloride 0.9% 5 ml Fill In 6 ml SYR  
 64054-0910-02 Sodium Chloride 0.9% 19 ml Fill In S

Also effective April 1, 2005, the following non-drug product codes (all package sizes) were deleted from the MDR Master file:

#### Labeler Code: 53303

0000	0012	0030	0082	0141
0006	0019	0070	0090	0142
0010	0022	0080	0100	0143
0011	0024	0081	0140	0144

#### Labeler Code: 00615

0369	0421	0587	0669	0686	0687	0692	0697	0870	3569	3594	4537
4560	4572	4574	4581	4584	4585	4586	4587	5517	5520	5522	5524
5528	5560	5561	5562	5563	5565	5567	5570	5571			

The above mentioned products were not approved as prescription drugs by the Food and Drug Administration (FDA) under Section 505 or 507 of the Federal Food, Drug, and Cosmetic Act and therefore, do not meet the definition of covered outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act.

---

## Holiday Schedule

The Division of Medical Assistance and EDS will be closed on Monday, May 30, 2005 in observance of Memorial Day.

---

## Electronic Cut-Off Schedule

April 29, 2005	June 3, 2005	July 8, 2005
May 6, 2005	June 10, 2005	July 15, 2005
May 13, 2005	June 17, 2005	July 22, 2005
May 20, 2005	July 1, 2005	

## Checkwrite Schedule

May 3, 2005	June 7, 2005	July 12, 2005
May 10, 2005	June 14, 2005	July 19, 2005
May 17, 2005	June 23, 2005	July 28, 2005
May 26, 2005	July 7, 2005	

*Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS claims must be transmitted and completed by 12:00 midnight on the day prior to the electronic cut-off date to be included in the next checkwrite*

---



Mark T. Benton, Interim Director  
Division of Medical Assistance  
Department of Health and Human Services



Cheryll Collier  
Executive Director  
EDS

---

e

P.O. Box 300001  
Raleigh, North Carolina 27622

<b>Presorted Standard</b> U.S. POSTAGE PAID Raleigh, N.C. Permit No. 1087
---

